Senate Bill No. 147

Passed the Senate September 10, 2015

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Secretary of the Senate

Passed the Assembly September 2, 2015

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2015, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Article 4.1 (commencing with Section 14138.1) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 147, Hernandez. Federally qualified health centers.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that federally qualified health center (FQHC) services, as described, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC and specified health care professionals. Existing federal law authorizes a state plan to provide for payment in any fiscal year to an FQHC for specified services in an amount that is determined under an alternative payment methodology (APM) if it is agreed to by the state and the FQHC and results in a payment to the FQHC of an amount that is at least equal to the amount otherwise required to be paid to the FQHC.

This bill would require the department to authorize an APM pilot project, to commence no sooner than July 1, 2016, for FQHCs that agree to participate. The bill would require the department to authorize implementation of an APM pilot project with respect to a county for a period of up to 3 years. The bill would require the department to determine an APM supplemental capitation amount for each APM aid category to be paid by the department to each principal health plan that contains at least one participating FQHC in its provider network, as specified. The bill would require, except as specified, the department to contract with an independent entity to perform an evaluation of the APM pilot project, and would require that the evaluation be completed and provided to the Legislature, to the extent practicable, within 6 months of the

conclusion of the APM pilot project in certain counties, as specified.

The people of the State of California do enact as follows:

SECTION 1. Article 4.1 (commencing with Section 14138.1) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 4.1. Payment Reform Pilot Program for Federally Qualified Health Centers

14138.1. For purposes of this article, the following definitions apply:

(a) "Alternative payment methodology" (APM) has the same meaning as specified in Section 1396a(bb)(6) of Title 42 of the United States Code.

(b) "APM aid category" means a Medi-Cal category of aid designated by the department. For all its APM enrollees in an APM aid category, a participating FQHC site shall receive compensation as described under the APM pilot project. The APM aid categories may include, but are not limited to, all of the following categories of aid:

(1) Adults.

(2) Children.

(3) Seniors and persons with disabilities.

(4) The adult expansion population eligible pursuant to Section 14005.60, to the extent the department determines, in consultation with health plans and interested FQHCs, that sufficient data is available to allow for inclusion of this population in the APM pilot project. This paragraph shall not be construed to prohibit inclusion of the adult expansion population in the APM pilot project on a date subsequent to initial authorization pursuant to subdivision (a) of Section 14138.12.

(c) "APM enrollee" means a member who is assigned by a principal health plan or subcontracting payer to a participating FQHC for primary care services and who is within one of the designated APM aid categories.

(d) "APM pilot project" means the pilot project authorized by this article.

(e) "APM scope of services" means the scope of services for a participating FQHC for which its per-visit rate was determined pursuant to Section 14132.100, but only to the extent those services are covered pursuant to the contract between the department and the applicable principal health plan.

(f) "APM supplemental capitation" means an additional, APM aid category-specific, PMPM amount that is paid by the department to a principal health plan having one or more participating FQHCs in its provider network.

(g) "Clinic-specific PMPM" means the monthly, per assigned member, capitated amount the principal health plan or subcontracting payer is required to pay to the participating FQHC for the APM scope of services. The clinic-specific PMPM is exclusive of any incentive payments and shall be developed to reflect the amount the participating FQHC would have received under the prospective payment system methodology set forth in Section 14132.100.

(h) "FQHC" means any community or public "federally qualified health center," as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code and providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States Code.

(i) "Member" means a Medi-Cal beneficiary who is enrolled with a principal health plan or subcontracting payer.

(j) "Participating FQHC" means an FQHC participating in the APM pilot project at one or more of the FQHC's sites. "Participating FQHC" also refers to an FQHC's site that is participating in the APM pilot project.

(k) "PMPM" and "per member per month" both mean a monthly payment made for providing or arranging health care services for a member and may refer to a payment by the department to a principal health plan, or by a principal health plan to a subcontracting payer, or by a principal health plan or subcontracting payer to an FQHC, or from and to other entities as specified in this article.

(*l*) "Principal health plan" means an organization or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.82 (commencing with Section 14087.98), Article 2.91 (commencing with Section 14089), or Chapter 8

(commencing with Section 14200), to provide or arrange for the care of Medi-Cal beneficiaries within a county in which the APM pilot project is implemented.

(m) "Subcontracting payer" means an organization or entity that subcontracts with a principal health plan to provide or arrange for the care of its members and contains one or more participating FQHCs in its provider network.

(n) "Traditional encounter" means a face-to-face encounter that is recognized as a billable visit, as described in subdivision (g) of Section 14132.100.

(o) "Traditional wrap-around payment" means the supplemental payments payable to an FQHC in the absence of the APM pilot project with respect to services provided to Medi-Cal managed care enrollees, which are made by the department pursuant to subdivision (e) of Section 14087.325 and subdivision (h) of Section 14132.100.

14138.10. The Legislature finds and declares all of the following:

(a) The federal Patient Protection and Affordable Care Act has made and continues to make significant progress in driving health care delivery system reforms that emphasize health outcomes, efficiency, patient satisfaction, and value.

(b) California has expanded Medi-Cal to cover more than 12 million residents, roughly one-third of the state's population. To meet the needs of the state's growing patient population, California must continue to explore new strategies to expand access to high quality and cost-effective primary care services.

(c) With such a large portion of the state's population receiving health care services through Medi-Cal, it is imperative that patient-centered innovations drive Medi-Cal reforms.

(d) Health care today is more than a face-to-face visit with a provider, but rather a whole-person approach, often including a physician, a care team of other health care providers, technology inside and outside of a health center, and wellness activities including nutrition and exercise classes, all of which are designed to be more easily incorporated into a patient's daily life.

(e) Accessible health care in a manner that fits a patient's needs is important for improving patient satisfaction, building trust, and ultimately improving health outcomes.

(f) In an attempt to invest up front in health care services that can prevent longer term avoidable high-cost services, the federal Patient Protection and Affordable Care Act made a significant investment in FQHCs.

(g) FQHCs are essential community providers, providing high quality, cost-effective comprehensive primary care services to underserved communities.

(h) Today FQHCs face certain restrictions because the current payment structure reimburses an FQHC only when there is a traditional encounter with a provider. Current law prohibits payment for both a primary care visit and mental health visit on the same day.

(i) A more practical approach financially incentivizes FQHCs to provide the right care at the right time. Restructuring the current visit based, fee-for-service model with a capitated equivalent affords FQHCs the assurance of payment and the flexibility to deliver care in the most appropriate patient-centered manner.

(j) A reformed payment methodology will enable FQHCs to take advantage of alternative encounters. Alternative encounters, such as group visits, same-day mental health services, and telephone and email consultations, are effective care delivery methods and contribute to a patient's overall health and well-being.

14138.11. It is the intent of the Legislature to test an alternative payment methodology for FQHCs, as permitted by federal law, and to design and implement the APM to do all of the following:

(a) Provide patient-centered care delivery options to California's expansive Medi-Cal population.

(b) Promote cost efficiencies, and improve population health and patient satisfaction.

(c) Improve the capacity of FQHCs to deliver high-quality care to a population growing in numbers and in complexity of needs.

(d) Transition away from a payment system that rewards volume with a flexible alternative that recognizes the value added when Medi-Cal beneficiaries are able to more easily access the care they need and when providers are able to deliver care in the most appropriate manner to patients.

(e) Track alternative encounters at FQHCs in order to establish a data set from which alternative encounters may be assigned a value that can be used in future ratesetting.

(f) Implement the APM where the FQHC receives at least the same amount of funding it would receive under the current payment system, and in a manner that does not disrupt patient care or threaten FQHC viability.

14138.12. (a) (1) The department shall authorize a payment reform pilot project for FQHCs using an APM in accordance with this article.

(2) Implementation of the APM pilot project shall begin no sooner than July 1, 2016, subject to any necessary federal approvals.

(3) The department shall authorize implementation of an APM pilot project with respect to a county for a period of up to three years.

(4) At least 90 days prior to implementation of an APM pilot project for a participating FQHC site in a county, the department shall notify a principal health plan in writing of the principal health plan's specific APM supplemental capitation rate for the participating FQHC in the county. The notification from the department to the principal health plan shall be based on the rates submitted by the department for federal approval. If the APM supplemental capitation rates are modified after the notification to a principal health plan, the department shall notify a principal health plan of the revised rates and, if the principal health plan requests, adjust the implementation date of the APM pilot project for a participating FQHC in a county so that it occurs at least 90 days after the revised rate notification.

(5) At least 90 days prior to implementation of an APM pilot project for a participating FQHC site in a county, the department shall notify a principal health plan and the FQHC site in writing of the clinic-specific PMPM rate for the participating FQHC site in the county.

(6) The APM pilot project for a participating FQHC site in a county shall begin no sooner than the first day of the month following the month in which the department received federal approval of the principal health plan's specific APM supplemental capitation rates.

(b) The APM pilot project shall comply with federal APM requirements and the department shall file a state plan amendment and seek any federal approvals as necessary for the implementation of this article. Nothing in this article shall be construed to authorize

the department to seek federal approval to affirmatively waive Section 1396a(bb)(6) of Title 42 of the United States Code.

(c) Nothing in this article shall be construed to limit or eliminate services provided by FQHCs as covered benefits in the Medi-Cal program.

14138.13. (a) The department shall notify every FQHC in the state of the APM pilot project and shall invite any interested FQHC to apply for participation in the APM with respect to one or more of the FQHC's sites. Consistent with federal law, the state plan amendment described in subdivision (b) of Section 14138.12 shall specify that the department and each participating FQHC voluntarily agrees to the APM.

(b) (1) The department shall develop, in consultation with interested FQHCs and principal health plans and consistent with federal law, the eligibility criteria to be used in evaluating applications from interested FQHCs for participation in the pilot project, which shall include, but need not be limited to, the following:

(A) The FQHC has the demonstrated ability to collect and submit encounter data in a form and manner that satisfies department requirements.

(B) The FQHC is in good standing with the relevant state and federal regulators.

(C) The FQHC has the financial and administrative capacity to undertake payment reform.

(2) In addition to the criteria listed in paragraph (1), the department may take into consideration the number of APM enrollees assigned by a plan at each FQHC site as an eligibility requirement for FQHC participation.

(3) In accordance with the process and criteria developed pursuant to paragraphs (1) and (2), the department shall approve or deny an interested FQHC site application for participation in the pilot project. The department may limit the number of participating FQHCs in the pilot project and the number of counties in which the pilot project will operate.

(4) All principal health plans and applicable subcontracting payers are required to participate in the APM pilot project pursuant to this article to the extent that one or more contracted FQHC sites located in the plan's county are selected to participate in the pilot project.

(c) The APM shall be applied only with respect to a participating FQHC for services the FQHC provides to its APM enrollees that are within its APM scope of services.

(d) Payment to the participating FQHC shall continue to be governed by the provisions of Sections 14087.325 and 14132.100 for services provided with respect to both of the following categories of patients:

(1) A Medi-Cal beneficiary who receives services from any FQHC to which the beneficiary is not assigned for primary care services under the APM pilot project by a principal health plan or subcontracting payer.

(2) A person who is a Medi-Cal beneficiary, but who is not a Medi-Cal beneficiary within a designated APM aid category.

(e) A participating FQHC, with respect to one or more sites of its choosing, may opt to discontinue its participation in the pilot project subject to a notice requirement of no less than 120 days.

14138.14. (a) A participating FQHC shall be compensated for the APM scope of services provided to its APM enrollees pursuant to this section.

(b) A participating FQHC shall receive from the principal health plan or applicable subcontracting payer reimbursement for each APM enrollee in the form of a clinic-specific PMPM for the applicable APM aid category. The department shall determine the clinic-specific PMPM for each APM aid category taking into account all the following factors:

(1) Historical utilization of FQHC services by assigned members in each APM aid category.

(2) The participating FQHC's prospective payment system rate and applicable adjustments relevant for the fiscal year, such as annual rate adjustments.

(3) Other trend and utilization adjustments as appropriate in order to reflect the level of reimbursement that would have been received by the participating FQHCs in the absence of the APM pilot project.

(c) A participating FQHC and applicable principal health plan or subcontracting payer may enter into arrangements in which the clinic-specific PMPM amount required in subdivision (b) is paid in more than one capitated increment, as long as the total capitation each month received by the participating FQHC is equivalent to the clinic-specific PMPM.

(d) In cases where a subcontracting payer is involved, the principal health plan shall demonstrate and certify to the department that it has contracts or other arrangements in place that provide for meeting the requirements in subdivision (b) and to the extent that the subcontracting payer fails to comply with the applicable requirements in this article, the principal health plan shall then be responsible to ensure the participating FQHC receives all payments due under this article in a timely manner.

(e) The department shall adjust the amounts in subdivision (b) as necessary to account for any change to the prospective payment system rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index pursuant to subdivision (d) of Section 14132.100, and any changes in the FQHC's scope of services pursuant to subdivision (e) of Section 14132.100.

(f) An FQHC site participating in the APM pilot project shall not receive traditional wrap-around payments pursuant to Sections 14132.100 and 14087.325 for visits within the APM scope of services it provides to its APM enrollees.

14138.15. (a) A principal health plan shall be compensated by the department for the services provided to its APM enrollees pursuant to this section.

(b) For each principal health plan that contains at least one participating FQHC in its provider network, the department shall determine an APM supplemental capitation amount for each APM aid category to be paid by the department to the principal health plan, which shall be expressed as a PMPM amount. This supplemental capitation amount will be in addition to the funding for the APM scope of services already contained in the principal health plan's capitated rates paid by the department and shall be actuarially sound. The department shall determine the APM supplemental capitation amount for each APM aid category, taking into account all of the following factors:

(1) The clinic-specific PMPM amounts for each APM aid category for each participating FQHC in the plan's network.

(2) The funding for the APM scope of services already contained in the principal health plan's capitated rates.

(3) The historical wrap-around payments paid by the department for participating FQHCs for assigned members in each APM aid category.

(4) As applicable, the likely distribution of members among multiple participating FQHCs.

(c) The principal health plan shall report to the department, in a form to be determined by the department in consultation with the principal health plan, the number of APM enrollees for each APM aid category in the plan each month.

(d) The department shall pay each principal health plan its applicable APM supplemental capitation amount for the number of APM enrollees for each APM aid category reported by the principal health plan pursuant to subdivision (c).

(e) The department, in consultation with the principal health plans, shall develop methods to verify the information reported pursuant to subdivision (c), and may adjust the payments made pursuant to subdivision (d) as appropriate to reflect the verified number of APM enrollees for each APM aid category.

(f) The department shall adjust the amounts in subdivision (b) as necessary to account for any change to the prospective payment system rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index pursuant to subdivision (d) of Section 14132.100, and any changes in the FQHC's scope of services pursuant to subdivision (e) of Section 14132.100.

14138.16. (a) For the duration of the APM pilot project, the department shall establish a risk corridor structure for the principal health plans relating only to the APM supplemental capitation payments pursuant to Section 14138.15, to the extent consistent with principles of actuarial soundness.

(b) The risk sharing of the costs under this section shall be constructed by the department so that it is symmetrical with respect to risk and profit, and so that all of the following apply:

(1) The principal health plan is fully responsible for all costs up to one-half of 1 percent in excess of the APM supplemental capitation amounts.

(2) The principal health plan shall fully retain the revenues paid through the APM supplemental capitation amounts in excess of the costs incurred up to one-half of 1 percent below the APM supplemental capitation amounts.

(3) The principal health plan and the department shall share equally in the responsibility for costs in excess of the APM supplemental capitation amounts that are greater than one-half of

1 percent but less than 1 percent above the APM supplemental capitation amounts.

(4) The principal health plan and the department shall share equally the benefit of the revenues paid through the APM supplemental capitation amounts in excess of the costs incurred that are greater than one-half of 1 percent but less than 1 percent below the APM supplemental capitation amounts.

(5) The department shall be fully responsible for all costs in excess of the APM supplemental capitation amounts that are more than 1 percent above the APM supplemental capitation amounts.

(6) The department shall fully retain the revenues paid through the APM supplemental capitation amounts in excess of the costs incurred greater than 1 percent below the supplemental capitation amounts.

(c) The department shall develop specific contract language to implement the requirements of this section that shall be incorporated into the contracts of each affected principal health plan.

(d) This section shall be implemented only to the extent that any necessary federal approvals or waivers are obtained.

14138.17. (a) In order to ensure participating FQHCs have an incentive to manage visits and costs, while at the same time exercising a reasonable amount of flexibility to deliver care in the most efficient and quality driven manner, for the duration of the APM pilot project the department shall, in accordance with this subdivision, establish a payment adjustment structure. The payment adjustment structure shall be developed with stakeholder input and shall meet the requirements of Section 1396a(bb)(6) of Title 42 of the United States Code.

(b) The payment adjustment structure shall be applicable on a site-specific basis.

(c) The payment adjustment structure shall permit an aggregate adjustment to the payments received when actual utilization of services for a participating FQHC’s site exceeds or falls below expectations that were reflected within the calculation of the rates developed pursuant to Sections 14138.14 and 14138.15. For purposes of this payment adjustment structure, both actual and expected utilization shall be expressed as the total number of traditional encounters that would be recognized pursuant to subdivision (g) of Section 14132.100 for the APM enrollees of the

participating FQHC's site across all APM aid categories and averaged on a per member per year basis.

(d) An adjustment pursuant to this section shall occur no more than once per year per participating FQHC's site during the APM pilot project and shall be subject to approval by the department.

(1) An adjustment to payments in the case of higher than expected utilization shall be triggered when utilization exceeds projections by more than 5 percent for the first year, 7½ percent for the second year, and 10 percent for the third year. If the trigger level is reached in a given year, the participating FQHC site shall receive an aggregate payment adjustment from the principal health plan or applicable subcontracting payer that is based upon the difference between its actual utilization for the year and 105 percent of projected utilization for the first year, the difference between actual utilization and 107½ percent of projected utilization for the second year, and the difference between actual utilization and 110 percent of projected utilization for the third year. The payment adjustment in each instance shall be calculated as follows:

(A) The actual total utilization, expressed as traditional encounters, for the applicable year shall be determined.

(B) The projected total utilization contained in the clinic-specific PMPMs for the actual APM enrollees for the applicable year shall be determined.

(C) The amount in subparagraph (B) shall be adjusted to reflect the applicable comparison utilization for the year as follows:

(i) Multiplied by 1.05 for year one.

(ii) Multiplied by 1.075 for year two.

(iii) Multiplied by 1.1 for year three.

(D) The amount in subparagraph (C) shall be subtracted from the amount in subparagraph (A).

(E) The amount in subparagraph (D) shall be multiplied by the per-visit rate that was determined pursuant to Section 14132.100 for the participating FQHC site yielding the payment adjustment for the participating FQHC site. The payment adjustment shall be paid to the participating FQHC site by the principal health plan, or subcontracting payer, as applicable, in one aggregate payment.

(2) (A) To incentivize care delivery in ways that may vary from traditional delivery of care, participating FQHCs shall have the flexibility to experience a lower than expected visit utilization of up to 30 percent of projected utilization. If an FQHC site's actual

utilization is at a level that is more than 30 percent lower than the projected utilization, the department shall review, in consultation with the principal health plan, or subcontracting payer, as applicable, the FQHC site's relevant data to identify the cause or causes of the difference, including, but not limited to, its volume of alternative encounters. If the department is able to determine that all or part of the lower than expected utilization was due to objective factors developed by the department in consultation with the principal health plans and FQHCs that are related to delivery system transformation and enhancements, such as alternative encounters, the department shall allow the participating FQHC site to retain all or a portion of the payments attributable to the utilization decrease that exceeds 30 percent lower than the projected utilization. If the department is unable to determine that all or a portion of the utilization decrease in excess of 30 percent was related to delivery system transformation and enhancements according to the objective criteria developed pursuant to this subparagraph, the participating FQHC site shall be required to refund the applicable payment amount to the principal health plan or subcontracting payer pursuant to subparagraph (B).

(B) The total amount refunded by the participating FQHC site to the principal health plan or subcontracting payer shall be limited to an amount calculated as follows:

(i) The actual total utilization, expressed as traditional encounters, for the applicable year shall be determined.

(ii) The projected total utilization contained in the clinic-specific PMPMs for the actual APM enrollees for the applicable year shall be determined and multiplied by 70 percent.

(iii) The amount in clause (i) shall be subtracted from the amount in clause (ii).

(iv) The amount in clause (iii) shall be multiplied by the participating FQHC site's per-visit rate that was determined pursuant to Section 14132.100, yielding the maximum amount of the refund to be made by the participating FQHC site. The refund shall be paid in one aggregate payment.

(C) Any adjustment made pursuant to this paragraph shall be requested by a principal health plan, subcontracting payer, or FQHC, no later than 90 days after that determination by the department pursuant to subparagraph (A).

14138.18. (a) The department, in consultation with interested FQHCs and principal health plans, may modify any methodology, process, or provision specified in this article to the extent necessary to comply with federal law or to obtain any necessary federal approvals.

(b) This article shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(c) In the event of a conflict between a provision in this article and the terms of a federally approved APM, the terms of the federally approved APM shall control.

14138.19. In the event of an epidemic, or similar catastrophic occurrence that the department determines is likely to result in at least a 30 percent increase in actual utilization per member per month within the APM scope of services for one or more APM aid categories at a participating FQHC site, the department may adjust, or require the adjustment of, payments made pursuant to this article as it deems necessary to account for the utilization increase at the affected participating FQHC site. The department shall make the determination described in this section upon written request of a participating FQHC site.

14138.21. Nothing in this article shall be deemed to affect the amounts paid or the reimbursement methodology applicable to FQHCs for dental services that are provided outside the scope of a contract between the department and an applicable principal health plan that is in effect as of July 1, 2015.

(a) The department shall contract with an independent entity to perform an evaluation of the APM pilot project authorized pursuant to this article. To the extent practicable, the evaluation shall be completed and provided to the appropriate fiscal and policy committees of the Legislature within six months of the conclusion of the pilot project in those counties that are included in the initial pilot project implementation authorized pursuant to paragraph (2) of subdivision (a) of Section 14138.12. The department shall carry out the duty imposed pursuant to this subdivision only if there are sufficient private foundation or nonprofit foundation funds available for this purpose. A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(b) The evaluation by the independent entity shall assess and report on whether the APM pilot project produced improvements in access to primary care services, care quality, patient experience, and overall health outcomes for APM enrollees. The evaluation shall include existing FQHC required quality metrics and an assessment of how the changes in financing allowed for alternative types of primary care visits and alternative encounters between the participating FQHC and the patient and how those changes affected volume of same-day visits for mental and physical health conditions. The evaluation shall also assess whether the APM pilot project's efforts to improve primary care resulted in changes to patient service utilization patterns, including the reduced utilization of avoidable high-cost services and services provided outside the FQHC. The evaluation shall also identify any administrative and financial implementation issues for FQHCs that may arise if subsequent legislation makes the pilot program operative statewide.

14138.22. (a) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(b) Beginning January 1, 2017, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature regarding any instruction issued by the department pursuant to subdivision (a) on a semiannual basis until six months after implementation of the pilot project authorized pursuant to this article.

(c) It is the intent of the Legislature, if the scope of the pilot project authorized by this article is extended, that the department adopt regulations to implement this article.

14138.23. For purposes of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Any contract entered into or amended pursuant to this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government

Code, and shall be exempt from the review or approval of any division of the Department of General Services.

Approved _____, 2015

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Governor